NAGURU TEENAGE
INFORMATION AND HEALTH CENTRE

STRATEGIC PLAN

JULY 2015 TO JUNE 2020

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ABBREVIATIONS

ADH	Adolescent health
ANC	Ante Natal Care
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
BCC	Behaviour Change Communication
CHAU	Community Health Alliance Uganda
FP	Family Planning
HCT	HIV Counselling and Testing
IEC	Information Education and Communication
KCCA	Kampala Capital City Authority
M&E	Monitoring and Evaluation
MoGLSD	Ministry of Gender Labour and Social Development
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NTIHC	Naguru Teenage Information and Health Centre
PAC	Post Abortion Care
PMTCT	Prevention of Mother to Child Transmission
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SYOFS	Strengthening Youth Friendly Services
UDHS	Uganda Demographic and Health Survey
YFS	Youth Friendly Service

1. INTRODUCTION

NTIHC has been implementing a five year strategic plan (2011-16). However, many things changed and much has been learnt during the first half of the plan period. For this reason, in 2014 NTIHC decided to review and re-work the plan. This document is the result: a new five-year NTIHC Strategic Plan for the period July 2015 to June 2020.

The process of reviewing and reformulating the plan involved NTIHC Board, staff and volunteers and stakeholders, and was supported by a consultant from RFSU.

The new Strategic Plan takes into account the current context of the health system and future projections for the young population of the country. It is designed to be feasible yet ambitious. It reflects NTIHC's sense of the contribution it can make and its niche role in the national programme to increase understanding of sexual and reproductive health (SRH) rights and access to appropriate youth-friendly services for young people.

The structure of this document is as follows. The background to the plan is provided in sections 2 and 3. Section 2 looks at the external context, focusing on sexual and reproductive rights, demography and age-related terminology and the sexual and reproductive health of young people in Uganda. It also clarifies the justification for NGO action on adolescent sexual and reproductive health and rights (ASRHR). Section 3 focuses on the internal context, briefly explaining NTIHC's history and describing the current portfolio of activities. The section then looks at NTIHC capacity and the lessons learnt from its work and various reviews and evaluations that have been conducted. Section 4 presents the updated results framework, introduces the three strategic plan objectives and describes how they will be implemented over time. Section 5 addresses management and finance, including governance, financial and human resource management, infrastructure and equipment, risk management, and partnerships. Section 6 provides details of arrangements for monitoring and evaluation, including baseline and endline studies, mid-term review and evaluation, operations research, and procedures for routine/ongoing monitoring and support. Section 7 contains the summary budget for the Strategic Plan.

The Plan has 8 annexes. These contain a description of the service packages provided by NTIHC (Annex 1), a summary of the NTIHC capacity self-assessment (Annex 2), the strategic plan logical and M&E framework (Annex 3), the work plan (Annex 4), organogram (Annex 5), risk analysis and risk management (Annex 6), the compiled budget (Annex 7), and the NTIHC Procurement Policy (Annex 8).

2. EXTERNAL CONTEXT

Section 2 looks at the external context, focusing on SRH rights, demography and age-related terminology and the SRH of young people in Uganda. It also clarifies the justification for NGO action on ASRHR.

2.1. Sexual and reproductive health rights

According to the *IPPF Charter Guidelines* (2003), sexual and reproductive rights cover:

1. The right to life
2. The right to liberty and security of the person
3. The right to equality, and to be free from all forms of discrimination
4. The right to privacy
5. The right to freedom of thought
6. The right to information and education
7. The right to choose whether or not to marry and to found and plan a family
8. The right to decide whether or when to have children
9. The right to health care and health protection
10. The right to the benefits of scientific progress
11. The right to freedom of assembly and political participation
12. The right to be free from torture and ill treatment

According to the IPPF document, Uganda has ratified each of the four international conventions on which the above list of rights is based, namely: International Covenant on Economic, Social and Cultural Rights; International Covenant on Civil and Political Rights; UN Convention on the Rights of the Child; UN Convention on the Elimination of All Forms of Discrimination against Women.

UNFPA[1] clarifies the link between sexual and reproductive health and rights, and the response of health services, as follows: 'Individuals have the right to control their sexual and reproductive lives and make reproductive decisions without interference or coercion. … The right to non-discrimination and respect for difference requires governments to ensure equal access to health care for everyone and to address the unique health needs of women, men and adolescents. The right to non-discrimination implies that reproductive health services should be accessible to all groups, including adolescents, unmarried women, indigenous people and migrants, including refugees. It also implies that services should be available to meet the distinct needs of women and men. … Governments are obliged to make comprehensive reproductive health services available and remove barriers to care, in order to fulfil people's rights to life and health'.

It is clear from the above that a commitment to sexual and reproductive health and rights requires active commitment to gender equality and an understanding of the particular needs and challenges and wishes of women and men, girls and boys. Rights will not be secured by a gender-neutral approach.

2.2. Demography and age-related terms

In 2014 the Census estimated Uganda's population to be 34.9 million, with a growth rate of more than 3% (one of the highest in the world). The country has a very 'young' population. The Census predicts that over 30% the total population are aged 10-24 years.

Various terms are in use to group the younger population. Teenager is a descriptive term covering people 13 to 19 years old. According to the Uganda Constitution, 'youth' are those 18 to 30 years. According to the National Adolescent Health-Strategy 2011-15 (Ministry of Health [MOH] 2011), an 'adolescent' is defined as a person aged 10 to 19 years. However, in Uganda the definition of 'young people' is 10 and 24 years of age. This helps to explain why the National Adolescent Health-Strategy states 'for the purpose of this strategy, the health sector programming focuses on the adolescents 10 - 19 years but services will cover up to individuals of 24 years'. For NTIHC, the target population is young people, i.e. those 10 to 24 years of age.

[1] http://www.unfpa.org/rights/rh.htm

AGE																				
10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
'adolescent'																				
			'teenager'																	
								'youth'												
'young people'																				
Adolescent Health-Strategy 'services will cover up to individuals of 24 years'																				

2.3. The sexual and reproductive health of adolescents in Uganda

Young people in Uganda face a wide range of sexual and reproductive health related challenges including teenage pregnancy, unsafe abortions, gender-based violence, drug and substance abuse, and sexually transmitted diseases (STDs) including HIV. As shown throughout this section, many of these challenges are particularly acute for girls and young women.

Despite Uganda having a predominantly young population, adolescent sexual and reproductive health services (ASRH) remain limited and do not address the full needs of adolescents and their sexual and reproductive health rights.

Early sexual debut is a major issue among young people in Uganda especially among females. According to the Uganda AIDS Indicator Survey (UAIS) of 2011 a larger proportion of young women (46%) than of young men (36%) aged 15-19 years report that they have ever had sex. Among young people aged 15-24 years in 2011, 13.1% of the females compared to 11.9% of the males had had their sexual debut before age 15 years. This early sexual debut does not tend to be accompanied by contraceptive use. The 2011 Uganda Demographic and Health Survey (UDHS) showed that in the 15 to 19 years age group, only 6% of all women, 13.1% married women, and 35.3% of sexually active unmarried women had ever used a modern family planning (FP) method. It also showed that only 6.8% of all women in that age group were currently using such a method. Consequently, there is a high rate of teenage pregnancy.

Government data suggests that unmet need for family planning is slowly decreasing, however according to the 2011 UDHS, unmet need for family planning still stood at 31% for women aged 15-19.

Teenage mothers account for roughly a quarter of maternal mortality in Uganda (which stands at 438/100,000 live births). The utilization of antenatal, delivery and post-natal care services by adolescents is poorer than in adults yet adolescents are at a greater risk of obstetric complications. Children born to adolescents are generally prone to higher morbidity and mortality due to poor prenatal and improper childcare practices. Infant mortality among adolescent mothers in Uganda is 105/1000 live births compared to the national average of 77/1,000 live births. Every year about 297,000 abortions are carried out in Uganda of which a large percentage of them are carried out by young girls. As the government comments in *A Promise Renewed* (2013) there is an 'intricate linkage of adolescent pregnancies to unsafe abortions and the resultant need for Post abortion Care services'.

'The five-year National Development Plan (2010/11-2014/15) acknowledges that limited access to family planning services hinders overall development of the society and of women in particular' UDHS (2011)

'Although declining, Uganda has one of the highest rates of adolescent pregnancy in Sub-Saharan Africa … with 24% giving birth to their first child before turning 19' MoH (2013) *A Promise Renewed*

The UAIS 2011 indicated that HIV prevalence among young females aged 15 to 17 years was 1.8% compared to 1.6% among males of the same age group. The data further shows that this difference between females and males increases with age. In the 18 to 19 year age group it is 5.1% for young women and 1.5% for young men; in the 20-22 years age group it is 7.1% versus 2.3%; and in the 23-24 years age group it is 7.0% versus 3.6%.

The higher prevalence of HIV among young females compared to young males could be due to the fact that young females are more vulnerable to un-protected sex than males. Explanations include differences in knowledge about prevention, transactional sex and cross-generational sex.

The 2011 UDHS reports 21% women aged 15-24 do not know that using a condom can prevent transmission of HIV (for men it is just over 16%). Indeed, only 38.1% women aged 15-24 have a comprehensive knowledge about HIV and AIDS[2]. The 2006 UDHS[3] reported that among those aged 15 to 24 years 10.6% % of both females and males reported receiving or giving gifts or money in exchange for sex. Cross-generational sex could also play a role. The 2006 UDHS reported that 7% of females aged 15 to 19 years who had had sex with non-marital, non-cohabiting partners in the past 12 months the partner was 10 years older.

Violence, especially gender based violence is another important factor of vulnerability for young people and impacts greatly on girls and young women. The 2011 shows a shocking degree of acceptance of wife-beating in Uganda, and a perhaps surprisingly higher acceptance among women than men; 58% women as opposed to 44% men believe that wife beating is justified for one or more reasons. In the 2006 UDHS it was shown that in the 15-19 years age group 56% of females and 51% of males had ever experienced physical violence and in the 20-24 years age group 55.8% of females and 60.8% of males reported this violence. However, with sexual violence the data showed that young females were more vulnerable than males. In the 15-19 years age group 21.3% of females and 7.4 % of males had ever experienced sexual violence and in the 20-24 years age group 40.9% of females and 9.1% of males reported sexual violence. It is therefore important that screening for gender based violence and referral for appropriate care and support become part and parcel of health services young people are accessing.

2.4. The ASRHR policy framework

The Government of Uganda has put in place policies aimed at improving the sexual and reproductive health of adolescents. These policies are geared towards the improvement of adolescents' health and life status by influencing future demographic trends and patterns in a desirable direction. Specifically the policies are targeted at reducing fertility, maternity mortality and child mortality, and increasing life expectancy. Through relevant policies and laws, the government of Uganda recognizes and emphasizes the salience of addressing ASRH by keeping children and adolescents in school, improving their sexual and reproductive health and increasing contraceptive use and levels of delivery attended by trained health personnel.

The *National Health Policy* (2000) provides the overall strategic direction for the health sector and its implementation guided by a *Health Sector Strategic Plan* (HSSP). The third Health Sector Strategic and Investment Plan, HSSP III, for the years 2010/2011 to 2014/2015 has, among others, specific targets defined for sexual and reproductive health and rights and for HIV/AIDS. A number of core interventions are defined to achieve the different SRH targets and one of these is: provision of a range of family planning services, with special emphasis on improving logistics and increasing availability to adolescents. One of the specific targets under STD/HIV/AIDS is: accessibility to information and services and improving access and availability of condoms to 100%.

The Government also addresses the need for adolescent friendly services. The purpose of the *Adolescent Health Policy Guidelines and Service Standards for Uganda* (MOH Oct 2011) is to guide stakeholders, programme officers and service providers on the criteria they should follow as they set up or scale up youth friendly services. The core package of interventions for adolescent-friendly services should comprise:

- Reproductive Health (pregnancy testing and counselling, antenatal care, maternity, newborn care to babies born to adolescents, Post-natal care, contraceptive counselling and provision of methods (including condoms and emergency contraceptives), post-abortion care (PAC) and management, sexually transmitted infections (STI) diagnosis and management
- Provision of HIV counselling and testing (HCT)
- Information provision and counselling on issues such as body changes, personal care and hygiene, nutrition, alcohol and substance abuse, reproductive health, STIs and life planning skills
- Assessment, detection and management of behavioural problems
- Management of sexual gender-based violence (SGBV)
- Referral of problems that cannot be managed.

[2] Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission or prevention.

[3] Note: not all data are replicated each time the UDHS is conducted, therefore in some cases previous data is cited.

On the specific topic of HIV prevention among young people, the *National HIV Prevention Strategy 2011-15* (UAC Nov 2011) identifies young people as a key target population. Within the strategies for reducing transactional sex the following actions which focus on young people are highlighted:

- Address the socio-economic and cultural factors that drive women and girls into transactional sex
- Eliminate sexual exploitation in education institutions at all levels
- Promote family centred approaches to parenting and skills development
- Promote programs that highlight the dangers of transactional sex among the youth
- Equip young people with life skills to resist transactional sex
- Ensure that all school going children are kept in school.

The Uganda HIV Counselling and Testing Policy 3rd Edition (MOH Dec 2010) outlines the following policies regarding HCT of children and young people:

- HIV testing for children under 12 years of age shall only be done with the knowledge and consent of parents or guardians, and the testing must be done in the best interest of the child
- Children 12 years and above can assent on their own for HCT. Approval of the parent or guardian shall not be mandatory. The provider however shall encourage disclosure of test results to significant persons for support.
- Confidentiality of test results of children shall be maintained and only shared with significant persons in the best interest of the child.
- Children who have been sexually abused and put at risk of HIV infection shall receive counselling and testing for HIV and be linked to appropriate services.

HIV care and support is a necessary service for young people. Young people may become infected through their own sexual behaviour, as a result of gender based violence, or through mother to child transmission (i.e. many such children are surviving into adolescence). Therefore, the *National Antiretroviral Treatment Guidelines for Adults, Adolescents, and Children* (MOH 2009) highlight the need for health workers who are able to deal with special issues of young people on ARV including issues about their love and sexual life, the need for FP and condoms as well as how to seek care without being accompanied by a parent/guardian.

The *National HIV/AIDS Strategic Plan* 2011/12 – 2014/15 (NSP) also highlights the need to promote and expand specialised HIV care for young people (UAC Dec 2011). One of the innovative ways to reach them is by taking services nearer to the young people i.e. during community outreaches whereby a big number of youth can be reached with these services.

The *Prevention of Mother to Child Transmission* (PMTCT) *Guidelines* (MOH 2011) provide the latest guidance on how to deliver PMTCT services to all HIV positive pregnant women including young mothers. There are four prongs for PMTCT and they are all relevant for adolescent sexual and reproductive services. Prong-1 is the primary prevention of HIV infection among girls and women of reproductive age. HIV prevention activities targeting young people especially girls are a major contribution to this prong. Prong-2 is the prevention of unwanted pregnancy among women living with HIV. ASRH services contribute to this prong by providing HCT to young girls and providing targeted counselling to those found HIV positive which includes family planning counselling. Prong-3 is the prevention of transmission of HIV from a HIV positive pregnant woman to her unborn child. ASRH services contribute to this service by providing ante natal care (ANC) to pregnant young girls including HCT and referring those found to be HIV positive for PMTCT services. Prong-4 is the provision of support to HIV positive mothers and their family. ASRH services contribute to this prong by involving male partners during ANC and providing them with HCT and referral to the couple or one of them for HIV treatment and care if found to be HIV positive.

The Safe Male Circumcision Policy (MOH 2010) aims at guiding safe male medical circumcision (SMC) services for all males in Uganda including those for young people as well as children and newborns as part of the HIV prevention package. Male circumcision has been proven to reduce by 60% the risk of males acquiring HIV during sexual intercourse. Based on this evidence the World Health Organization and United Nations Program on AIDS (UNAIDS) issued in 2007 a recommendation that male circumcision should be considered as part of a comprehensive HIV prevention package. Uganda has endorsed this recommendation and has hitherto developed its male circumcision policy whose objective is to improve access to quality SMC services at all levels in both public and private health facilities carried out by appropriately skilled personnel.

Other policies and guidelines are supportive of the health package for young people. While socio-economic support is not the direct responsibility of the MOH it is an essential component of health services for young people and providers of health services for young people should have referral linkages to providers of socio-economic support. The following national policy areas are relevant:

- Nutritional counselling: in the *National Policy on Food and Nutrition* (MOH and MOA 2003), which was jointly developed by both the MOH and the Ministry of Agriculture (MOA), it is stated that under-nutrition is wide-spread in Uganda affecting children, young people as well as women of child bearing age among others. One of the policy's specific objectives is to reduce under-nutrition among young people and women of reproductive age
- Socio-economic support: many young people are living in poverty and are lacking basic necessities such as food, shelter and clothing either because they are out of school and unemployed or because they are living in vulnerable households. One special group of vulnerable children is orphans. In the *National Policy on Orphans and Vulnerable Children* (MoGLSD 2004) it is stated that many orphaned children are forced to live on the street, or in child headed households where they are sexually abused or subjected to prostitution and are vulnerable to HIV and teenage pregnancy
- In the *National AIDS Strategic Plan* (NSP) it is also stressed that many orphaned girls and boys are forced to engage in paid labour and become exposed to various risks including early sexual initiation. The Ministry of Gender Labour and Social Development, in the *National Gender Policy* (MoGLSD 2007), also emphasizes that access to livelihood by young people remains a major challenge. Hence male young people are vulnerable to alcohol, drug abuse and crime. There is also a major disparity between males and females on the right to property and livelihood leading to a need for gender specific interventions to improve livelihood
- The *National Policy on HIV and the Work Place* (MoGLSD 2010) also states that in the process of looking for work young women become vulnerable to unwanted sexual approaches as well as sexual abuse. Thus comprehensive sexual and reproductive health services for young people should include social economic support or income generating activities or referral for the same in order to reduce the vulnerability of these young people to high risk situations.

2.5. The response to adolescent SRH needs and SRH rights

Despite a largely positive/conducive policy framework for ASRHR, the current state of the health sector response is not good. The public health sector experiences perennial problems around stock-outs of drugs and supplies, human resources (recruitment, retention and adequate pay, etc.), management and delivery structures (operation of Health Unit Management Committees and VHT structures, etc.), and infrastructure (buildings, equipment, transport, etc.).

Specific to SRHR and young people, according to Health Sector Strategic and Investment Plan 2010 only 10% of public health facilities in Uganda provide adolescent friendly sexual and reproductive health services[4]. Since this data was gathered, it is assumed that the % must have increased due to civil society and government investment in adolescent health (ADH). However there is not yet the hard data to demonstrate any improvement of the situation.

Monitoring of government achievements on ASRH has been hindered by a) the age-categorisation used in the Health Management Information System means that it is hard to 'see' adolescents unless primary research is conducted with facility records, and b) the fact that spending specific to ADH is not identifiable in government budget data. On a positive note, a new approach to age categorization is scheduled to come into effect early in 2015. This will distinguish the age groups of 10-19, 20-24, and >25. This will help significantly to show trends among young people using health services.

It is important to acknowledge that the Government's Adolescent Health Policy Guidelines and Service Standards (2011, p. 37) confirm that: 'Most people including adolescents are not aware of their reproductive rights, rights to information, and services … there is need for adolescents themselves, service providers and significant others to be informed and oriented to these rights in order to better meet adolescents' sexual and reproductive health needs'. This clarifies the government's commitment to the concept of adolescent SRH

[4] One target of Health Sector Strategic and Investment Plan is 'The proportion of health facilities that are adolescent-friendly increased from 10% to 75%.'

rights. It also encourages civil society and other actors to work towards informing and empowering adolescents regarding these rights, and working with service providers to increase the quality of, and access to, youth-friendly services.

The area of sexual rights has, however, received a lot of attention in the media and in parliament. An Anti-Homosexuality Law was passed and then subsequently repealed. There are ongoing attempts to reinstate that legislation. In addition there are some concerns that the public order management act may impact on the advocacy activities of NGOs. Even so, rights-based approaches are greatly supported by the government's position as stated in the Second National Health Policy (2010) which reminds us that the 1995 Constitution 'provides for all people in Uganda to enjoy equal rights and opportunities (and) … have access to health services'.

2.6. Justification for action on ASRHR

Sections above clearly identify that there is major unmet need for initiatives to address sexual and reproductive health services and sexual and reproductive health rights of young people in Uganda. Young people are a large population group with some particular needs. Lack of understanding of SRH rights and/or inability to realise those rights has a devastating impact on young people themselves as well as the social and economic development of the country. Young women are especially affected because gender norms and gender inequalities add further barriers and challenges on top of those faced by young people in general. .

This need for more to be done on young people's SRHR is clearly understood by government, civil society, and development partners. There is widespread need for civil society organisations to work with public health facilities to establish and improve youth friendly services and promote understanding of SRHR for young people. There is also a niche role for an organisation to lead the field in terms of demonstrating best practises in youth friendly services (YFS) and shaping the policy and resources environment in favour of adolescent SRHR.

3. INTERNAL CONTEXT

Section 3 focuses on the internal context, briefly explaining NTIHC's history and describing the current portfolio of activities. The section then looks at NTIHC capacity and the lessons learnt from its work and various reviews and evaluations that have been conducted.

3.1. Brief history of NTIHC

Naguru Teenage Information and Health Centre (NTIHC) was founded in 1994 under Kampala City Council. At that time it was located at the Naguru Health Centre IV in Nakawa Division. In 2009, NTIHC shifted to Kiswa Heath Centre in order to give way for the construction of a district hospital. Over time, NTIHC has developed into a fully-formed information and health centre and an organisation with a wider programme on adolescent sexual and reproductive health and rights. In 2014 NTIHC completed a major step in its development by formally registering as an NGO.

In the early days, financial support came from DANIDA, UNICEF and UNFPA, and over the years the organisation has successfully mobilised funds from a number of resource providers. However, since 2004, NTIHC's main funding partner has been the Swedish Embassy. Important non-monetary contributions have also been forthcoming from the former Kampala City Council and current Kampala City Council Authority (KCCA), Ministry of Health, and other partners.

NTIHC is now coming towards the end of the third year of its five year strategic plan (2011/12 – 2015/16). Much has changed and much has been learnt during those three years, during which organisational activities were at times shaped too heavily by external stakeholders. This resulted in reduced control and feelings of ownership for NTIHC, and some major work commitments that were not matched by human and physical resources to do the job. To rectify this situation, NTIHC decided in 2014 to review its situation and develop a new strategic plan. The move was supported by the Swedish Embassy, NTIHC's main donor. The process began with support from a consultant from RFSU, provided through a technical support contract by the Swedish Embassy.

3.2. Current activities

Current activities can be grouped into three components.

First, NTIHC provides a comprehensive package of ASRH services as directed by the MoH *Adolescent Health Policy Guidelines and Service Standards* (2011). These services include: HIV counselling and testing; STI/STD diagnosis, treatment and management; maternal health services i.e. (ANC, post-natal care, PAC, pregnancy testing); SGBV and related services; condom education and distribution, other medical services relating to ASRH. These are supported with various behaviour change communication (BCC) interventions. These services are provided either at NTIHC's facility at the Kiswa Health Centre or by NTIHC staff and volunteers during outreach services in surrounding catchment areas. Currently, all services are provided free of charge.

Second, NTIHC has been working to help establish and strengthen youth friendly services in various public health facilities in other parts of the country. In 2013-14, for example, this support stretched to 53 public health facilities across 21 districts. This was achieved through partnerships with the Swedish Embassy and Uganda Red Cross Society, Community Health Alliance Uganda, Uganda Youth Development Link and UNFPA. Packages of support vary, but overall NTIHC has provided trainings, mentorships, coaching and periodic support supervision, as well as providing infrastructure, tools, ASRH guidelines and enforcing policies and service standards.

The service packages relating to these first two components are described in Annex 1.

Third, there is NTIHC's policy, advocacy and capacity development work. NTIHC expertise is shared to promote adolescent sexual and reproductive health rights through various channels with government and civil society. These include Technical Working Groups (on Adolescent Health, Maternal Health and BCC), opportunities for practitioners to benefit from 'experiential learning' at Kiswa (practicums and internships), and various trainings focused on ADH policy and guidelines and youth friendly services.

3.3. NTIHC capacity

NTIHC capacity was analysed in a detailed self-assessment exercise. This was done using a tool provided by RFSU and the plan is to repeat the assessment at regular intervals to monitor changes in organisational capacity (in addition to other data, for example from audits, reviews and evaluations, etc.). The following areas were considered: management, SRHR technical, advocacy, and co-operation and partnerships with other actors. Annex 2 contains a summary of the results.

SRHR technical capacity is assessed to be good overall. This supports NTIHC's ongoing efforts to be and be recognised as a centre of excellence in ASRHR programming. The one notable area where capacity is recorded as low relates to knowledge and skills in the area of sexual orientation and gender identity. Overall, SRHR advocacy capacity is also strong. However the analysis identifies the lack of a guiding strategy for NTIHC's advocacy work.

Organisational management capacity is assessed to be relatively robust, though some areas for strengthening are identified, such as the functioning of the Board, strategic management, and meaningful involvement of relevant rights holders.

Lastly, the self-assessment records that NTIHC is strong on co-operation and partnerships with other actors. Even so, partnership is recognised as such a fundamentally important way of working for NTIHC that there is a full commitment to further strengthen co-operation and networking efforts.

The capacity assessment exercise also includes a section exploring whether NTIHC has provided technical support or training to other organisations in specific topics on the list. These scores illustrate that NTIHC has a good degree of capacity and experience in training others on specific topics of YFS.

3.4. SWOT analysis

Strengths, weaknesses, opportunities and threats have been analysed and are summarised below.

	Positive	Negative
Internal	**Strengths** • Expertise in delivering ASRH services • Good record of receiving, utilizing and accounting for resources • Emerging capacity to mobilise resources • Resourceful team with a good mixture of skills that can be shared • NTIHC is a success story of partnership between public sector, civil society sector and development partners • Commitment to capacity building and learning opportunities for staff and others • Generally good morale among staff • Attitude of 'making the most of' challenging physical conditions at Kiswa • Clear legal identity through NGO registration	**Weaknesses** • Do not own premises • Challenging nature and quality of infrastructure (use of containers, limited space, etc.) • Difficult to plan and budget when you provide services on demand • Continued reliance on one main source of funding • Insufficient learning and sharing to add to body of knowledge on ASRH • Over-sensitivity to the perceived risks of openly adopting a rights based approach • Tendency to stay within comfort zone • Over complicated M&E which creates very heavy burden
External	**Opportunities** • Recognised as a leader in ASRH in Uganda • Clear need for capacity building in ASRHR for government, service providers, CSOs, etc. • Growing interest on ASRHR among actors • Favourable policy environment for ASRHR work • National Adolescent Health Policy due to be reviewed and updated • Demographic change strengthens the need for organisations like NTIHC • Growing relevance of social media in ASRHR programming	**Threats** • Uncertain future of donor funds • Conflicting or restrictive messages coming from leaders on ASRH • Uncertain direction of policies and laws that could impact on ASRHR work • Uncertain future of KCCA partnership • Some cultural norms and values do not support all aspects of best practise ASRHR work • Negative impact of potentially positive innovations in health and social development (moral hazard)

3.5. Lessons learnt

Over the years NTIHC has maintained a steep learning curve. Lessons emerge from everyday practise, staff and management team meetings, interactions with clients and stakeholders, ad hoc analyses, and formal processes such as reviews and evaluations and audits.

Most recently, NTIHC has undergone the formal processes of a Strengthening Youth Friendly Services (SYOFS) project evaluation in early 2013, a Programme Review in late 2013, and an overall evaluation in mid- to late 2014. Each process looked at a different combination of the Strategic Plan objectives.

STRATEGIC PLAN 2011-16	SYOFS Evaluation 2013	Programme Review 2013	Overall Evaluation 2014
Objective-1: To provide quality ASRH services at NTIHC facilities and improve client satisfaction as well as provider performance		✓	✓
Objective-2: To strength ASRH service provision in selected health facilities in at least nine districts of the Central Region by 2016	✓		✓
Objective-3: To strength ASRHR behaviour change communication and advocacy activities in at least nine districts of Central Region by 2015		✓	✓
Objective-4: To create and strengthen partnerships and resource mobilization and advocacy for financing ASRHR in order to increase public funding for ASRHR and to diversify sources of funding for NTIHC		✓	✓

From these processes, the following key lessons have emerged:

- **Continual quality improvement.** NTIHC seeks to inspire and build the skills of others, as a centre of excellence. This in itself requires NTIHC to stay informed of Ugandan and global developments in SRHR, continually analyse its work and seek to improve the quality and youth friendliness of services
- **Continually improve BCC.** The Programme Review showed that NTIHC had made good progress on implementation of behaviour change communication. However, to stay abreast of best practises it is important to routinely review and update BCC, ensure that the full scope of topics in the BCC SOPs are covered, and maintain adequate supplies of the relevant materials to support BCC work
- **NTIHC cannot meet all needs directly; a strategic role is required.** NTIHC came into being as a service provider. However, the numbers of clients that NTIHC can serve directly will always remain relatively small compared to the need that exists in Uganda, Kampala, and even in NTIHC's immediate environment. It is an important lesson that NTIHC cannot do everything itself. It is as a trainer and mentor, as an advocate and technical advisor, as a supporter and encourager of others, that NTIHC is able to make the greatest progress towards its goals and governmental goals on ADH
- **The value of partnerships.** Working with partners is a way to achieve more results, better results, or results over a wider geographical area. Many different types of partnerships are possible for NTIHC, including government and government health facilities, direct peers (i.e. civil society organisations implementing youth friendly SRH services), and a wider group of civil society organisations that work in the fields of youth or health
- **Advocacy strategy.** To strengthen results a strategy is required for NTIHC's advocacy work. This should identify the main targets and approaches to be used, and the main messages to promote.
- **Appropriate investment in human and physical resources.** In recent years, NTIHC has been attempting to implement activities on a scale far beyond the organisation's capacity to deliver (i.e. support to over 30 health facilities in surrounding districts). This arose due to demands and restrictions placed on NTIHC by external stakeholders but it created an impossible situation. An important lesson is to ensure that all future plans are fully owned by NTIHC and achieve a correct balance between the ambition and scale of activities and the inputs of human and physical resources to deliver them
- **Learning and sharing lessons.** The Programme Review challenged NTIHC to scale up efforts to 'extract and publish its best practices and challenges … so that all its experience can be used as "data for

decision makers" to influence policy direction'. NTIHC also has a wealth of SRH service data that could be used for research purposes; this data source needs to be better exploited

- **Diversification of financial support.** NTIHC has made efforts to develop new funding relationships with resource providers. However, its reliance on the Swedish Embassy continues. During this new Strategic Plan, NTIHC needs to redouble efforts to diversify its financial support.

3.6. Results-based approach

The new NTIHC strategic plan and results framework have been developed to be results-based, ensuring a strong logic between planned activities and desired outcomes. The results framework is intended to be challenging but also realistic over time. In developing the strategic plan, NTIHC has paid close attention to issues of:

- **Need:** What needs are there and which, in particular, are not being addressed by current provision? What are the needs of young people, service providers, gate-keepers and decision-makers, civil society, and government?
- **Gender:** How can NTIHC strategies and activities promote gender equality and serve the particular needs of women and girls, as well as men and boys?
- **Capacity:** Does NTIHC have the capacity (knowledge, skills, human resources, time, partnerships, etc.)
- **Niche:** What is NTIHC especially good at? In which areas of ASRHR can NTIHC make the most significant contribution? Are there things that NTIHC can do that others cannot?
- **Opportunity costs:** Is this the best way to use NTIHC? If NTIHC takes on the activities outlined in the strategic plan will it mean that it is not able to do other more important things?
- **Strategic potential:** What is needed to 'change the game' of ASRHR in Uganda? Where can strategic actions potentially yield significant results?
- **Partnership:** Ways of working with government, civil society and others to achieve shared goals.

4. RESULTS FRAMEWORK

Section 4 presents the NTIHC results framework. This includes an explanation of NTIHC's vision, mission, and values, the goal and objectives. This section also explains that this strategic plan has been designed according to a 'core' and 'project' model.

4.1. Vision, mission, values and guiding principles

NTIHC's vision, mission and core values remain unchanged:

- **Vision:** A society of young people empowered in adolescent sexual reproductive health and their rights.
- **Mission:** To advocate for and promote access to quality Adolescent Sexual and Reproductive Health Services and information to young people
- **Core values:** youth friendly services, confidentiality, gender equity, a right to choice, a right to evidence-based information, and integrity
- **Guiding principles:**
  - ***Services:*** NTIHC values provision of quality youth friendly services to young people regardless of race, gender, education status or religious affiliation. Provision of timely and appropriate information to young people; young people make well informed decision if given accurate information
  - ***Clients:*** NTIHC values meaningful participation and involvement of young people in its programmes. The work of NTIHC is guided by respect and acceptance of clients as they are
  - ***NTIHC staff:*** NTIHC values staff with a high level of commitment to serving young people. NTIHC values team work among its staff. NTIHC values time management because staff time is considered one of the most valuable resources of the organization
  - ***Other providers of ASRH services:*** Meaningful partnership with various stakeholders in ASRH complements NTIHC programs and fills gap that NTIHC is unable to fill. NTIHC values sharing of knowledge in a mutual respectable way among partners. NTIHC believes in learning from others as others also learn from NTIHC.

4.2. Goal, objectives and strategic design

The NTIHC goal has been reviewed and updated, and the main performance questions[5] have been identified:

> *Goal:*
> *Increased understanding of SRH rights and access to appropriate youth-friendly services for young people*[6]
>
> *Performance questions:*
> *1) Do young people in Uganda have a better understanding of their SRHR?*
> *2) Is access to youth friendly SRH services increasing?*

NTIHC has identified three strategic objectives that logically will bring progress towards the goal:

- **Objective 1: Best practise.** To provide excellent youth friendly SRH services at Kiswa health centre and in the surrounding community, and share best practices with practitioners by providing them with practical learning opportunities

[5] These are the main, general questions to be answered by project M&E. They can be answered using quantitative and qualitative data, including the routine data from indicators, case studies, primary and secondary research data etc.
[6] Note: this goal is based on and is worded very similarly to the government's Standard 3, stated in the Adolescent Health Policy Guidelines and Service Standards (2011), which states: All adolescents are informed of their sexual and reproductive health rights and services whereby these rights are observed by all service providers and significant others

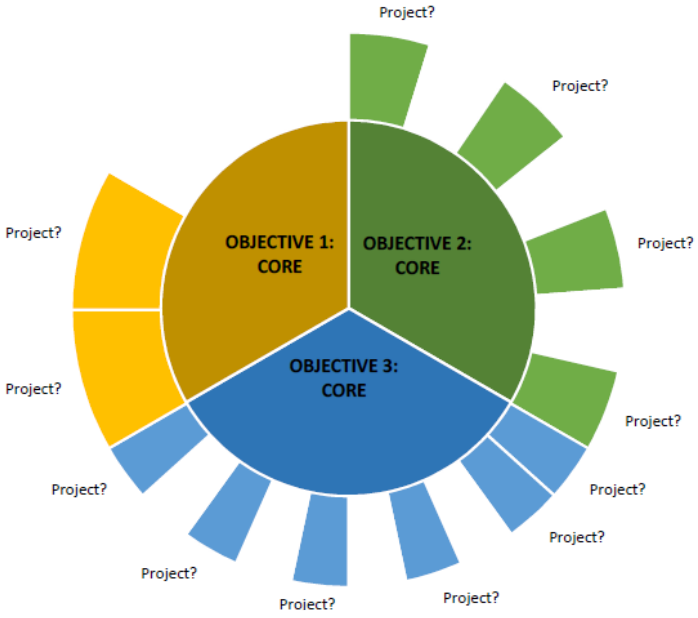
- **Objective 2: Scale up.** To expand and improve youth friendly SRH services in selected public health facilities by providing material and technical support
- **Objective 3: Promote ASRHR.** To increase awareness, understanding and acceptance of young people's SRH rights and advocate for a more enabling environment for ASRHR.

The sections below explain these three objectives in more detail. The annexes provide the strategic plan logical framework and M&E framework (Annex 3) and the detailed work plan (Annex 4).

This strategic plan has been designed according to a 'core' and 'project' model (captured in the image opposite). This means that the plan focuses on a core group of activities and results a) that NTIHC will achieve and b) that should be fully funded at the start of the strategic plan period through core donor support.

Over time opportunities will arise for additional 'project' activities to add to the core activities. These project activities must each bring their own project-specific funds. All project opportunities must clearly fit with the strategic plan objectives and goals.

The feasibility and desirability of each project possibility will be assessed according to a) potential contribution to desired results, b) value of the partnership (for profile, learning, relationship-building), and c) bearing in mind NTIHC capacity to undertake them successfully given organisational capacity and infrastructure.



4.3. Objective 1: Best practice

Objective:
To provide excellent youth friendly SRH services at Kiswa health centre and in the surrounding community, and share best practices with practitioners by providing them with practical learning opportunities

Performance questions:
1) Is NTIHC providing quality ASRH services at Kiswa?
2) How is quality improved and maintained?
3) What is being learnt about ASRH services?
4) How is best practise being demonstrated to others?

This objective relates to SRH services provided at the NTIHC located at the Kiswa Health Centre in Kampala. NTIHC will continue to provide adolescent sexual and reproductive health and rights services on demand. During the strategic plan period, NTIHC will continue to push to improve the range and quality of the services offered in order to demonstrate best practise.

Objective 1 is important in terms of direct service provision (to meet the needs of thousands of clients in the local area) but also because the NTIHC provides a model of best practise to encourage and challenge others, continue the search for improvements in ASRH programming, and provide learning opportunities to others.

The main activities under objective 1 are:

- Facility-based service delivery, including: medical diagnosis screening and treatment; counselling on ADH issues; condom distribution and promotion; HIV counselling, testing, care and treatment;

information education and communication (IEC) development and distribution; and maternal health services
- Community-based service delivery, including: medical diagnosis screening and treatment; counselling on ADH issues; condom distribution and promotion; HIV counselling and testing; IEC development and distribution; and maternal health services
- Capacity building, including: training and learning opportunities for NTIHC staff; provision of learning opportunities for others (practicums and internships); quality control and improvement
- M&E, research, and documentation, including routine data collection, operations research and documentation of best practises.

Most of the services provided by NTIHC are 'on demand' so projections of client numbers are not exact. However, based on existing data and trends, it is expected that there will be:

Over the 5 years of the strategic plan …	
At the Naguru facility itself	**In the local community**
@ 60,000 to 70,000 young people diagnosed and treated for STIs	@ 1,000 to 1,500 young people provided with medical services
@ 2 to 2.5 million condoms distributed	@ 400,000 to 500,000 condoms distributed
@ 3,000 to 4,000 young people provided with modern contraceptive method	@ 1,500 to 2,000 young people provided with modern contraceptives
@ 20,000 to 30,000 young people provided with HCT	@ 6,000 to 7,000 young people provided with HCT
@ 13,000 to 17,000 young people provided with ANC services	

Over time an important evolution is planned under this objective area. The evolution is intended to improve service quality and make the package of ASRH services demonstrated by Naguru more comprehensive. This evolution is illustrated below.

The table also highlights the possibility that additional ad hoc project activities may be added over time (see the 'project' row); each such opportunity will be assessed on its own merits in terms of contributing to the strategic plan objectives and goals. NTIHC is keen to pilot HPV vaccination but requires MOH partnership and specific project funding to be able to undertake this due to the significant costs involved. Given this, for the first year of the strategic plan, project activities will consist of the 'Seventh Country Programme' project in collaboration with Uganda Red Cross Society. This involves technical support to URCS and UNFPA supported districts aimed at effective and quality implementation of ASRH project in 12 districts focusing on in-school and out-of-school youth.

	Objective 1: Best practise				
	2015-16	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Core - ongoing	- Package of ASRH services (as of January 2015)	- Package of ASRH services (now including SMC) - Continue to pilot HIV testing by counsellors - Updated BCC work	- Package of ASRH services (including HIV testing by counsellors if pilot successful) - Updated BCC work	- Package of ASRH services (including HIV testing by counsellors and clinical HIV care and treatment if pilots successful) - Updated BCC work	- Package of ASRH services (including HIV testing by counsellors and clinical HIV care and treatment if pilots successful) - Updated BCC work

	Objective 1: Best practise				
	2015-16	2016-17	2017-18	2018-19	2019-20
Core - new	- Conduct safe male circumcision - Pilot of HIV testing by counsellors - Build capacity of service providers on rights based approach - Review BCC approaches and materials to ensure emphasis on rights		- Pilot of clinical HIV care and treatment - Introduce basic care kit for PLWH (as per MOH guidelines)		
'Project'	- Capacity building for Uganda Red Cross / UNFPA - Other to be decided	- To be decided	- To be decided	- To be decided	- To be decided

4.4. Objective 2: Scale up

Objective:
To expand and improve youth friendly SRH services in selected public health facilities by providing material and technical support

Performance questions:
1) Has NTIHC scaled up ASRH service provision?
2) Has this managed/reduced the load on the Kiswa facility?
3) Is the sustainability of scaled up ASRH service provision increasing?

This objective focuses on scaling up ASRH service provision in the country. The term 'scaling up' covers aspects of 'more' and 'better'.

In the core of the strategic plan, NTIHC will provide a substantial package of support to 9 public health facilities in and around Kampala. These facilities are: Bweyogerere, China Uganda Friendship Hospital, Kawaala, Kawempe*, Kiruddu*, Kisenyi, Kisugu, Kitebi, Komamboga. Two of these (marked with *) are under construction at the time of developing this plan and the aim is to start working with them in the third year of the strategic plan.

This component of the plan serves two purposes:

- It is important in terms of helping the public health authorities to meet the needs of thousands of clients in areas of Kampala and Wakiso. This is a valid objective in its own right but its achievement also helps to reduce the risk of the NTIHC facility being swamped by excessive demand, i.e. surrounding facilities need to be strengthened and their services scaled up to mitigate the risk of that too many young people will migrate to the Kiswa facility rather than get what they need in their local area
- Second, this component is also important to enable NTIHC to develop and test lessons being learnt at the Kiswa facility, and lessons about the most effective ways of partnering with public facilities to achieve scale up of ASRH services.

Also in the core of the strategic plan, NTIHC will provide ongoing mentoring and technical support to the 24 facilities it previously supported under NTIHC's SYOFs programme in the districts of Wakiso, Luwero, Nakaseke, Mukono, Kayunga, Mpigi, Butambala and Gomba.

As with objective 1 above, NTIHC embraces the possibility that additional ad hoc project activities may be added over time, and understands that the package of provided to supported facilities may vary.

For the first year of the strategic plan, project activities will consist of the Link Up project in collaboration with CHAU. This involves working to increase health seeking behaviours and uptake of quality integrated maternal health, family planning and HIV information, services and commodities amongst young people (10-24 years) affected by HIV and uphold their sexual and reproductive rights. The project involves building capacity for enhancing the integration of SRHR/HIV services at the project sites. NTIHC will be implementing this project in Kampala, Mukono and Kayunga districts. One of the facilities covered by the Link Up project, Bweyogerere, will transition to become one of the 9 supported facilities in the core of the strategic plan in 2015-16.

Also the project with Uganda Red Cross / UNFPA will continue into the first year of the plan involving field visits to provide technical support supervision.

The main activities for objective 2 are:

- 'Service delivery package' of support to 9 facilities
    - Allowances to service providers and peer educators (in recognition of the additional roles required of them and the additional activities involved, e.g. outreaches specifically aimed at young people)
    - Material support, including: IEC materials; drugs and supplies; infrastructure support (e.g. drug storage equipment, audio visual equipment)
- 'Capacity building package' of support to 24 facilities across Wakiso, Luwero, Nakaseke, Mukono, Kayunga, Mpigi, Butambala and Gomba, consisting of mentoring and technical support and some provision of IEC materials
- Advocacy with facility and district officials, community leaders, civil society organisations
- Capacity building, including training of service providers and peer educators on ADH and YFS, and ongoing technical support supervision
- M&E, research, and documentation, including routine data collection, monitoring visits, and operations research.
- Link Up project package to selected facilities in Kayunga, Mukono and Buikwe district, including 240 Integrated community outreaches, 4 reproductive health camps for young people from most at risk populations, dialogue meetings with community gatekeepers, 250 BCC outreaches using drama or film van, training for service providers and peer educators
- URCS project activities including practicum placements at NTHIC for 52 health workers and 52 peer educators from 18 health facilities in the 8 UNFPA focus districts.

(As seen above for objective 1) most of the services provided by the facilities supported under objective 2 are 'on demand' so projections of client numbers are not at all exact. However, based on existing data and trends, it is expected that over the course of the strategic plan the facilities covered by the service delivery package of support will achieve:

At the 9 'service delivery package' facilities over the 5 years of the strategic plan
@ 210,000 to 230,000 young people provided with HCT
@ 135,000 to 150,000 young people provided with modern contraceptive methods
@ 60-70,000 young people diagnosed and treated for STIs
@ 50-60,000 young people provided with ANC services

The timetable for objective 2 is outlined overleaf:

	Objective 2: Scale up				
	2015-16	2016-17	2017-18	2018-19	2019-20
Core - ongoing	- Service delivery package of support to 6 facilities[7] - Capacity building package of support to 24 facilities	- Service delivery package of support to 7 facilities (see 2015-16) - Capacity building package of support to 24 facilities	- Service delivery package of support to 7 facilities (see 2016-17) - Capacity building package of support to 24 facilities	- Service delivery package of support to 9 facilities - Capacity building package of support to 24 facilities Reduced support / sustainability measures if decided by MTE	- Service delivery package of support to 9 facilities - Capacity building package of support to 24 facilities Reduced support / sustainability measures if decided by MTE
Core - new	- Service delivery package of support to 1 new facility[8]		- Service delivery package of support to 2 new facilities[9]	- No new facilities unless decided by MTE	- No new facilities unless decided by MTE
'Project'	- Link Up (partnering with CHAU) - Support to URCS for the UNFPA / GoU 7th Country Program - Others to be decided	- To be decided	- To be decided	- To be decided	- To be decided

It has already been decided to analyse the sustainability issues to do with this support as part of the strategic plan mid-term evaluation. The MTE will explore whether there is scope to 'wean off' facilities from NTIHC support and, if so, how and over what time period.

With additional 'project' funds, NTIHC may consider providing scale up support to other facilities. Any growth in the number of facilities under the service delivery package of support is relatively unlikely due to the significant monitoring and field support burdens involved. A higher likelihood and a higher priority for NTIHC will be to support the scale up process by activities undertaken under objective 3 which focuses on increasing understanding of rights and ways of securing rights or young people through health service improvements.

4.5. Objective 3: Promote ASRHR

Objective:
To increase awareness, understanding and acceptance of young people's SRH rights and advocate for a more enabling environment for ASRHR

Performance questions:
1) In what ways has NTIHC promoted ASRH services and ASRHR in Uganda?
2) What have been the challenges and what results have been achieved?

[7] China UFH, Kawaala, Kisenyi, Kisugu, Kitebi, Komamboga

[8] Bweyogerere - set up in 2015, start early 2016

[9] Kawempe, Kiruddu. Both of these facilities are still under construction at the time of drafting this strategic plan, but they should be fully operational by 2016-17.

This objective focuses on ways to promote sexual and reproductive health and rights for young people. There are many potential aspects to this process. It covers raising awareness and understanding of rights among diverse target groups (e.g. the general public, young people, service providers, government), as well as raising understanding of government ADH policy and guidelines and ADH best practises among service providers and health managers. Promotion also covers the improvement of services through actions such as policy reform, improvements to health systems, and the financing of ADH services. In virtually all aspects of this objective, NTIHC plans to work in partnership with other organisations and institutions.

This objective is important because it is the way NTIHC seeks to alter the national landscape of ASRHR. As a small Kampala-based organisation NTIHC cannot directly implement youth friendly services across the country. But through strategic inputs and strategic interventions, NTIHC hopes to improve the situation for ASRHR (understanding of and support for rights), and improve the availability and quality of ASRH services in the public health sector.

The main activities for objective 3 include:

- Advocacy and technical advice, including: contribution to key government Technical Working Groups (TWGs) and the scheduled review and revision of the National Adolescent Health Strategy and Policy; advocacy aimed at district and national authorities; advocacy with 'mass movement' fora of young people or affecting young people; media (radio and TV); and production and dissemination of information and communications products
- Capacity building, including: training of service providers and CSOs ADH and YFS; producing and distributing ADH policies and guidelines;
- M&E, research, and documentation.

The nature of policy and advocacy work is unpredictable, however it is expected that over the course of the strategic plan NTIHC will:

Promoting ASRHR over the 5 years of the strategic plan
Contribute to and positively influence the new National Adolescent Health Strategy and Policy
Connect and collaborate with mass movement fora reaching young people
Increase understanding and adoption of SRH rights for young people through media, training duty bearers and civil society groups, and advocacy

Some of this work is relatively new to NTIHC and so a step by step approach is planned:

	Objective 3: Promote ASRHR				
	2015-16	2016-17	2017-18	2018-19	2019-20
Core - ongoing	- TWGs - Radio and TV programmes on ASRH rights - Capacity building of service providers and CSOs	- Continue with TWGs, media, and capacity building - Implement advocacy strategy targeting points of influence	- Continue with TWGs, media, capacity building, and advocacy strategy - Popularise/explain new ADH Policy and Strategy	- Continue with TWGs, media, capacity building, advocacy strategy and explaining new ADH Policy and Strategy	- Continue with TWGs, media, capacity building, advocacy strategy and explaining new ADH Policy and Strategy
Core - new	- Develop NTIHC advocacy strategy - Contribute to review / development of National Adolescent Health Policy and Strategy	- Popularise and explain the new National Adolescent Health Policy and Strategy			
'Pr	- To be decided	- To be decided	- To be decided	- To be decided	- To be decided

5. MANAGEMENT AND ADMINISTRATION

5.1. NTIHC governance and management

In 2014 NTIHC successfully obtained its NGO registration which was an institutional capacity and legal challenge. The Constitution was updated to meet the current legal status. The Board signed all organizational policies documents that had remained shelved for some time. This is a step forward in improving the governance structure significantly.

The NTIHC organogram is presented in Annex 5.

All important decisions and policies of NTIHC are developed by the Board which has a Chairperson and eight members including representation from the KCCA, directorate of health services and environment. The board members were selected purposively basing on their areas of expertise in various aspects of sexual and reproductive health. The board meets at least three times in a fiscal year to guide, review and approve work plans and budgets.

The board has three committees which meet before formal board meetings are held. They report progress and findings to the main board meeting. The committees are Finance, Programme, and resource mobilisation.

The Program Director is the Chief Executive Officer of the Organization and is responsible for the day to day management of the organization and for the implementation of policies, plans, strategies and budgets approved by the Board. The Director is supported by a Deputy Director, who is also Head of Department for Advocacy and Research. The Director, Deputy Director, Head of Department for Finance and Administration and Head of Department for Service Delivery form the NTIHC management team, which meets every Monday afternoon. Managers have clear budgets and work-plans and have operational responsibility for the work of their department. Managers are required to collect, manage and report on department activities in the management meetings. They also justify decisions taken basing on informed information from the implementation of activities and the data collected.

Monthly meetings are also held with all members of staff. Each department also has weekly meetings. At these meeting the performance of NTIHC is discussed at different levels with different implementing groups.

5.2. Financial management

The NTIHC finance department oversees all budgets and they account for all funds passing through the organisation. The finance department comprises of a Finance and Administration Manager supported by Administrative Assistant and an Accountant.

NTIHC is guided by a well-updated accounting manual that specifies access, utilisation and accountability of its funds. The manual serves as a reference document for the Programme Director, Finance and Administration Manager, the Accountant, departmental mangers and auditors. It incorporates conventional financial management and accounting principles and tailor-made arrangements specifically designed to suit the peculiar operational dynamics of the organization. It basically covers the major aspects of the management of NTIHC's financial resources.

NTIHC currently uses Pastel accounting software package to report all its financial transactions. The Pastel software is micro-soft supported and its license is renewed annually. With technical support from Kisaka and Company the software was redesigned to align with NTIHC's charts of accounts and accounting system with specific emphasis to customized financial reports tailored to user needs.

NTIHC plans to add the Multistores module to the Pastel system, which will significantly improve the tracking of medicines and supplies passing through the stores and dispensary. This will improve stores management, financial management, control, and procurement planning.

The NTIHC Procurement Policy is included in Annex 8.

Every year NTIHC's accounts undergo an annual external audit in August.

In terms of banking, NTIHC currently operates five accounts[10] since donors often require designated accounts. In a new development, a foreign currency account will be opened in early 2015 as required by the main donor and in preparation for receipt of funds raised for this strategic plan.

5.3. Human resources

NTIHC employs staff on contracts linked to the time period for which core funding has been secured. Besides the individuals on the payroll, volunteers are also brought on board to assist in providing the services. NTIHC has its own Human Resource Manual which guides the human resource management of the organization.

At the start of 2015, NTIHC had 34 individuals on the staff list. Roughly half have a medical professional background (gynaecologists, registered midwives, enrolled midwifes, dispenser, laboratory technologists). The other staff members have other professional backgrounds (social scientists, statistician, information technology, finance, management, or trained as peer educators/data clerks). It should be noted that some of the categories, such as peer educators, do not appear in the structures of local governments yet, these it has be observed that they are very resourceful in reaching to the adolescents very easily. Some of the staff have started as volunteers and have been trained on job. Training has been encouraged by the management both in the form of in-service training and external training. Team building is also pursued through staff meetings, annual retreats and structures such as communal lunches.

As mentioned above in section 3.5, NTIHC has been facing a major challenge of being required to implement a scale of activities way beyond its capacity to deliver. This strategic planning process has allowed Naguru to adjust workload and address some key staffing gaps. For the delivery of the new strategic plan some internal re-organisation will be effected and three new staff are required: a project officer to join the Service Delivery Department to support scale up activities under objective 2, a project officer to join the Advocacy and Research Department to add capacity in advocacy, technical support and capacity building, and a part time driver. All posts are shown in the new organisational structure in Annex 6.

As an effort to keep staff focused, accountable and updated on the various project activities that have happened in the concluded month and plans for the upcoming month, a staff meetings is held on the first Thursday of every new month. During these meetings various departments present their reports to the meeting to include achievements, challenges and lessons learnt plus the new month's plans are shared.

5.4. Infrastructure, equipment and supplies

The geographical location of NTIHC is good, on the plot of the Kiswa Health Centre, Bugolobi, Kampala. This locates NTIHC in close proximity to a resident client group and a government facility for referrals and support, and within easy reach of government offices and those of peer civil society organisations in Kampala. However NTIHC's buildings are small in size and quite poor in quality. NTIHC premises currently comprise:

- A wooden structure that houses the Programme Director, most of the Managers, and the organisation's administration department, as well as five treatment rooms including the dispensary
- Two metal shipping containers that have been refurbished to house three counselling rooms, storage closet, a computer room for data entry and two rooms that accommodate the IT and M&E offices. These containers are placed 5 meters parallel apart and the space between them serves as the waiting room for the young people waiting to be served. However, the rooms in the containers plus the waiting area tend to be uncomfortable especially during the hot seasons
- The antenatal services are housed in a semi-permanent open-sided shelter with two rooms at the end of it for treatment and counselling. This shelter is also uncomfortable especially during the rainy seasons.

Given the above, NTIHC operates in an environment that is cramped and noisy. A long term goal for NTIHC is to secure new more conducive premises. This fundraising effort will be an ad hoc initiative outside of the core of the funded Strategic Plan.

[10] 2 Embassy of Sweden accounts (current and savings), 1 for URCS-related activities, 1 for CHAU-related activities, 1 for any income generated funds

At NTIHC, internet connection and power supply are at times intermittent, although there are procedures in place to mitigate the impact of this. Overall, NTIHC is relatively well equipped with computers though some replacement of outdated machines will be required over the 5 years of the plan. Data storage and back-ups are regular and secure.

One area of investment required in IT is the organisation's database. At present there is reliance on a data base that was developed by a team of micro-soft student volunteers in 2005. This has over the years supported data collection and report writing, but the data set is now getting massive and the system requires a fundamental overhaul and investment in a new more user-friendly database set-up. A new system will make NTIHC data more accessible for research purposes, as well as much more user-friendly for routine M&E.

At the start of 2015 NTIHC had four vehicles[11]. However, two of these have served for over 10 years and are not in very good mechanical condition; they are expensive to maintain. Given projected future requirements, a new minibus is required at the beginning of the plan period and a replacement double cab vehicle in year 4.

5.5. Risk analysis and risk mitigation

NTIHC has begun to periodically update its analysis of risk and planning of risk mitigation measures. In Annex 7, the main risks are identified at the goal level, for each objective, and for organisational management and finance. In each case, the assessment involves analysis of:

- Probability: how likely is it that something actually happens - high, medium or low?
- Potential impact: how much it could affect results if it did happen
- Risk management/mitigation – whether to accept the risk (because it cannot be managed) or have a strategy to try and make sure that the risk does not happen, or to reduce the impact if it does happen.

NTIHC has also considered the systems that need to be in place to ensure regular attention to risk analysis and risk management. These include ongoing review as part of everyday management decision making, organisational policies and procedures (including financial control), 6 monthly review, and reporting on risks and updating risk analysis and management in each annual report/annual plan.

5.6. Partnerships

NTIHC's work is supported by and often done in partnership with government ministries especially the Ministry of Health and the Ministry of Gender, Labour and Social Development (MoGLSD). In addition NTIHC and has well established relations a number of CSOs and projects, including AIDS Information Centre (AIC), Reproductive health Uganda (RHU), DSW, Uganda Youth Development Link (UYDEL), Community Health Alliance (CHAU), Straight Talk Foundation (STF), The AIDS Support Organization (TASO), Maternal health Project, United Nations Population Fund (UNFPA), World Health Organization etc. Further, at the community level NTIHC works closely with local community based organizations in delivering outreach services.

NTIHC has been able to partner at three levels—policy, advocacy and implementation. At the advocacy level NTIHC has participated in major national level events relevant to ASRH such as World Population Day, International Youth Day, World AIDS Day, Day of the African Child and International Women's Day. At the implementation level, NTIHC has formed partnerships with a number of CSOs and to deliver ASRH through MOH health facilities in a number of districts. Other approaches are through conducting BCC events targeting young people such as teen bashes and sports galas.

NTIHC considers partnerships to be one of its most valuable resources. Over the next three years NTIHC shall maintain and strengthen existing partners but also it will continue to refine its links with other various strategic partners in the provision of ASRH services. Apart from the working with ASRH providers in Uganda, NTIHC will work with district officials in the scale-up districts and heads of health centres in other districts including Kampala. Wherever possible these relationships will be clearly spelt out in Memoranda of Understanding.

[11] Ford double cab pick-up acquired in 2013, Toyota double cab pick-up acquired in 2008, Coaster Bus acquired in 2003, and Suzuki Jimminy acquired in 1998

5.7. Review, planning, budgeting and reporting cycle

NTIHC's review, planning and budgeting cycle will follow an annual pattern. In addition there will be specific requirements associated with specific projects and donors.

Timing	Task
Weekly or monthly	Review of progress on work plans and budgets
March onwards	Preparation of annual work plans and budget
August	Annual audit (as described above section 5.2)
By end of August	Annual narrative and financial reports (covering all organisational activities for the period July to June)

6. M&E AND RESEARCH

This section explains NTIHC's approach to routine monitoring, plans for the mid-term and final evaluations, and operations research during the strategic plan period.

6.1. Routine monitoring

NTIHC uses performance questions, targets, projections and indicators for planning and M&E purposes:

- **Performance questions**. These are the main, general questions to be answered by project M&E. They can be answered using quantitative and qualitative data, including the routine data from indicators, case studies, primary and secondary research data etc.
- **Targets**. These what NTIHC aims to achieve. This might be a number of activities or a 'state of affairs' (e.g. all clients receive the service they require when they present at the clinic). Targets are set either for annual achievement or for achievement by the end of the strategic plan.
- **Projections**. These are required for financial and human resource budgeting purposes. A projection is an estimate of how many clients may need to be served for specific services.
- **Indicators**. These are the routine data to be collected and reported to monitor progress of implementation.

The specific data relating to these targets, projections and indicators are specified in the M&E framework, work plan or budget (see Annexes 5, 4 and 8 respectively).

The strategic planning process included a fundamental review and re-think of the NTIHC M&E framework. The objective was to create an M&E framework that provides valuable monitoring and evaluation data to track progress and assess achievement of results, while being much simpler to operate and much easier to understand for the wider staff group. The goal is to collect less data, but use the data that is collected in a more rigorous way for learning and shaping of management decisions. As seen in Annex 5, three main sources of data will be used for M&E purposes: primary research data (for example on levels of understanding of SRH rights among young people), routine project monitoring data, and routine health service utilisation data derived from the government's HMIS.

In operationalizing its approach to M&E, NTIHC conducts routine collection and analysis of service data at Kiswa facility and community-based data for all outreaches and other community-based activities. Besides the daily data collection at Kiswa, monthly data is also received from health facilities directly supported by NTIHC. Service data at Kiswa is directly entered into a computer system (real time) and automatically backs up in electronic database. Service data from supported health facilities is compiled in paper forms which is then entered into computer system and backed up in a separate database at Kiswa. Biannual survey on quality of services and client satisfaction is also conducted to measure changes in quality of services as well as clients' perceived satisfaction with the quality of services provided.

Naguru will collect service data monthly and analyse the data quarterly, to track performances and progress of the activities and for sharing with staff for internal utilization.

Annual progress reports will be prepared for the scrutiny of the Board and funding partners.

NTIHC will further conduct joint (with district health teams) quarterly field monitoring and technical support and supervision to supported health facilities to assess progress. Activity specific reports will be prepared and shared to all health facilities in joint review meetings.

6.2. Mid-term and final evaluations

A mid-term evaluation (MTE) has been pencilled in for half way through the plan period, i.e. late 2017/early 2018. This is intended to provide an opportunity for NTIHC and stakeholders to reflect on progress and sharpen the focus for the remainder of the strategic plan period, if required.

Under each objective, some specific key issues for the MTE (in addition to the general performance questions) have already been identified, including:

- Objective 1: assessment of the pilots for HPV vaccination and HIV testing by counsellors, and review of the new BCC strategy that emphasises rights
- Objective 2: sustainability issues and whether there is scope to 'wean' the supported facilities from NTIHC support
- Objective 3: review of the new advocacy strategy targeting points of influence, and assessment of NTIHC's influence over the new ADH strategy.

In addition, it will be important for NTIHC to review progress on organizational capacity and the development of new funding relationships and partnerships.

The MTE is intended to be a participatory self-review process, with technical support from RFSU if that relationship continues to the mid-point of the strategic plan. Peer organisations supported by the Swedish Embassy and RFSU have found this approach particularly helpful in terms of promoting ownership, reflection and learning among staff and partners, and in terms of improving the relevance and value of any corrective actions.

An external final evaluation is scheduled towards the end of the strategic plan period (late 2019 or early 2020). The evaluation will focus on achievement and lessons learnt and feed into the development of the next iteration of the strategic plan.

6.3. Operations research

The main operations research activities are linked to the baseline and endline

NTIHC has an established monitoring system that will provide baseline information for most routine indicators. Similarly, the new M&E framework will provide most of the data required for endline reporting at the conclusion of the strategic plan period. All of this routine data will be either collected directly by NTIHC staff or collated from government HMIS data sources. The utility of the HMIS data will be greatly improved by the proposed introduction of a new age categories that clearly identify young users of health services.

In addition, there are some new data that need to be collected to clarify the baseline and endline situations. In particular, this strategic plan places greater emphasis on knowledge and understanding of SRH rights among young people and service providers. This cannot be tracked by means of routine monitoring data or HMIS data, so primary research by NTIHC is required at baseline and endline.

In addition to the baseline and endline, NTIHC will conduct other operations research studies that contribute to the strategic plan objectives. Budget has been allocated for years 2, 3 and 4 of the plan (since year 1 includes major baseline work and year 5 major endline studies). These studies may be conducted by NTIHC staff or contracted out to external researchers, as required. Under each Objective, some potential studies have already been identified, including:

- Objective 1: results of service delivery pilots and BCC interventions, community perceptions about the quality of NTIHC services
- Objective 2: analysis of stock outs (frequency and impact) of essential SRH drugs and supplies for young people, sustainability issues for supported facilities
- Objective 3: meaningful involvement of young people in SRH rights advocacy and ADH service planning and implementation by facilities and CSOs.

6.4. Overall map of M&E

2015-16	2016-17	2017-18	2018-19	2019-20
Baseline study		Mid-Term Evaluation		Endline study Final Evaluation
<<< ongoing routine monitoring and ad hoc operations research for core strategic plan>>>				
<<< monitoring and operations research specific to any additional projects >>>				

7. BUDGET

As mentioned earlier, NTIHC's strategic plan has been developed according to a 'core' and 'project' model. The budget reflects this design and therefore has been developed to show the full costs of all core activities and the known costs of any projects that are occurring in the strategic plan period.

The NTIHC strategic plan July 2015 – June 2020 has been costed to UGX 15,852,196,319 UGX. This means NTIHC spending will continue at roughly the same general level as for the period 2011-15. This arises from an active strategic management decision to pursue continuity rather than any significant change in terms of levels of funding. Staying at current funding levels ensures ability to execute the budget and deliver results as NTIHC capacity grows.

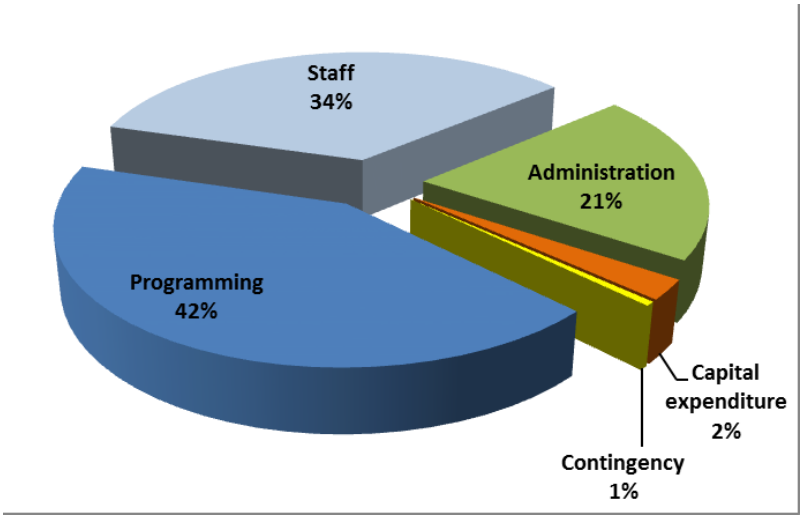
The budget prepared for this strategic plan has the following features: includes all costs for all core activities; includes all costs for all known project activities (i.e. CHAU and URCS in year 1); assumes NTIHC will begin the strategic plan with the commitments and relationships to fully cover costs of all core and known project activities; identifies all proposed contributions (in cash or financial value of goods provided in kind) from all resource providers (Swedish Embassy, MoH, KCCA, CHAU, URCS, AIC, and others); shows annual totals for each of the 5 years, overall plan total, programming costs broken down by objective, details of management costs; 5% annual inflation assumed for years 2 onwards.

Annex 7 contains the detailed budget. The summary budget breakdown is shown overleaf:

Over the years of the strategic plan, the budget shows a general growth year-by-year according to expected inflation and the phasing-in of new activities. In the first year, the budget is higher because of the inclusion of known project activities (CHAU and URCS). Each year's plan and budget is feasible in terms of budget execution and associated workload.

In terms of the objectives, the budget shows a 3, 2, 1 ratio. Objective 1 is costed at roughly UGX 3.4 billion. This objective requires heavy investment to demonstrate best practise and provide a comprehensive package of services to the thousands of clients that rely on NTIHC at Kiswa. Objective 2 is costed at just over UGX 2 billion. This covers service delivery or capacity building support to health facilities in and around Kampala to ensure scale up of SRH services. Objective 3 requires a smaller budget to fund a series of strategic advocacy and media activities to promote ASRHR in Uganda. Objective 3 is costed at just under UGX 1.2 billion.

In the budget breakdown, there is a considerable total for 'management'. Importantly, this budget area includes all staffing costs, most of which are directly attributable to programming activities, not administrative duties. To better illustrate the allocation of the budget, see the pie chart opposite which attempts to break down costs between programming, staff (most of which are also programming), administration, capital expenditure, and contingency.



NTIHC will formally request a contribution of UGX 13,347,594,479 (SEK 38,040,644) from its major donor, the Swedish Embassy. This represents @84% of overall total. As noted above, the remaining 16% of the budget is met by financial contributions or the value of contributions in kind from MoH, KCCA, CHAU, URCS, AIC and others.

Over the years of the strategic plan, the addition of new projects should change this balance to show more diversity of the funding base over time. For the next strategic plan, NTIHC aims to establish a donor consortium rather than relying on one main donor to cover the costs of the core activities.

	2015-16	2016-17	2017-18	2018-19	2019-20	TOTAL (UGX)	Total (SEK)
Objective 1	634,479,000	602,431,550	693,964,528	722,359,374	731,855,007	3,385,089,459	9,647,505
Objective 2	658,814,000	328,066,200	372,833,528	405,393,329	400,546,990	2,165,654,047	6,172,114
Objective 3	235,132,010	187,019,510	214,009,760	224,323,648	311,230,761	1,171,715,688	3,339,390
Management	1,805,388,842	1,609,358,255	1,748,162,597	1,932,652,030	1,955,308,753	9,050,870,477	25,794,981
Contingency	16,669,069	13,634,378	15,144,852	16,423,642	16,994,708	78,866,648	224,770
TOTALS (UGX)	3,350,482,921	2,740,509,893	3,044,115,264	3,301,152,022	3,415,936,218	**15,852,196,319**	45,178,760

LIST OF ANNEXES

The program intends to contribute to the realization of the ICPD (International Conference on Population and Development) Program of Action and Millennium Development Goals (MDGs), specifically MDG3 (gender equality), MDG5 (maternal health) and MDG6 (HIV/AIDS, TB and malaria). By joining forces and increasing synergy between the different organizations and activities, impact will be increased.

The program works towards:

- Strengthening the health systems to deliver high quality comprehensive Sexual Reproductive Health services to all young people including marginalized groups;
- delivering high quality Comprehensive Sexuality Education to both in-school and out of school youth;
- capacity building for communities;
- Increasing the understanding of all aspects of sexuality and reproduction among the target groups;
- strengthening the Civil Society Organizations and local structures in their capacity to lobby and advocate at local and national level for improved policies, legislation or funding and strive for the implementation of existing policies;
- Strengthening the linkage between Comprehensive Sexuality Education and Youth Friendly Services

We provide Health and Community Systems strengthening through:

- Work place policies and service delivery
- ARVs, drugs for STIs
- Capacity building (Comprehensive Condom Programming, Counselor Training, Laboratory Technicians Trainings, M&E Trainings, SGBV Trainings, Nutrition and Psychosocial Support Trainings among others)
- Strategic planning and HIV&AIDS mainstreaming (support District to develop and align their strategic plans to the national priorities, support districts to mainstream HIV&AIDS in their work plans, facilitate HIV&AIDS review and formulation processes)
- Coordination structures (Regional Planning and review meetings, DOC, NOC, DACC, SACC, National MARPs Steering Committee, National Technical Working Groups)

- Community structures (Capacity building for CBOs, Village Health Teams (VHTs) Peer Educators for key and priority population, Young positives, discordant couples, Know your HIV status clubs)
- M&E Systems (Training of Local Governments in M&E, Building of Local Government Staff Capacity in the use of HMIS tools, data collection, data entry, data cleaning, data analysis, reporting, feedback and data use for evidence informed decision-making).
- Joint Support Supervision (AIC, MoH, IPs and Local Governments)
- Radio programs (Talk shows, spots, DJ mentions, Announcements)
- Edutainment (music, dance and drama, flash-mobs, documentaries, videos)

Capacity building

Access to **sexual and reproductive health** information and services is still a challenge for young people in Uganda. We work with young people through schools, youth groups and communities to **raise awareness on HIV, family planning** and other sexual and reproductive health issues. We train health centre staff to deliver **youth-friendly services** and work with government and service providers to strengthen local referral systems, ensuring that young people are able to access the information and services that they need.

We provide HIV&AIDS laboratory Services including but not limited to:

- CD4/8 cell counts and percentages
- EID services
- Malaria tests (B/S and RDTs)
- Referral services (for Viral load, Liver function, Renal function, Genexpert tests)